REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE STATE DEPARTMENT OF MENTAL HEALTH DOES NOT ENSURE THAT COUNTIES COLLECT REVENUE FROM INSURERS AND DOES NOT MAINTAIN ACCURATE DATA ON SOURCES OF PAYMENT FOR CLIENTS

P-715 **FEBRUARY 1988**

REPORT BY THE

OFFICE OF THE AUDITOR GENERAL

P-715

THE STATE DEPARTMENT OF MENTAL HEALTH DOES NOT ENSURE THAT COUNTIES COLLECT REVENUE FROM INSURERS AND DOES NOT MAINTAIN ACCURATE DATA ON SOURCES OF PAYMENT FOR CLIENTS

FEBRUARY 1988

Telephone:
(916) 445-0255

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

Thomas W. Hayes
Auditor General

February 3, 1988

P-715

Honorable Bruce Bronzan, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 448
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the State Department of Mental Health's enforcement of policies and procedures for collecting revenues from health insurers and its collection of accurate data for its Client Data System.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

TABLE OF CONTENTS

SUMMARY

RESULTS IN BRIEF

The State Department of Mental Health (department) does not enforce state requirements for billing health insurers for mental health treatment. As a result, for the three counties that we reviewed, we estimate that the State's mental health system lost approximately $653,000 in revenue collectable from health insurers during fiscal year 1985-86. In addition, the department has not complied with state laws requiring it to maintain accurate data on the potential sources of payment for clients receiving treatment in the mental health system. During our audit, we noted the following specific conditions:

- In fiscal year 1985-86, Alameda, Los Angeles, and San Francisco counties failed to bill health insurers for an estimated $2.3 million (32.4 percent) of the $7.1 million that it cost to provide mental health treatment to insured clients; and

- For Alameda and Los Angeles counties, the department maintains inaccurate data concerning whether mental health clients have health insurance.

In appendices A and B, we respond to the Legislature's request for information concerning the types and terms of mental health coverage and the cost of providing mental health care to insured clients in the three counties that we reviewed. In Appendix B, we also respond to the Legislature's request for an estimate of how much the mental health system could save if all private health insurers covered mental health treatments.

BACKGROUND

The department coordinates the State's mental health system, and the counties operate treatment programs and collect revenue. During fiscal year 1985-86, Alameda, Los Angeles, and San Francisco counties spent approximately $206.7 million (45.8 percent) of the $451.3 million that it cost to provide mental health treatment statewide. Health insurers are not required by law to provide mental health coverage. However, if all health insurers provided mental health coverage, Alameda, Los Angeles, and San Francisco counties could have collected an estimated $6 million for treatments given in fiscal year 1985-86.

In March 1985, the Office of the Auditor General issued a report entitled "The State's Mental Health System Could Be Operated More Cost-effectively and Could Better Meet the Needs of Clients," Report P-441. We reported that the department did not ensure that counties comply with state requirements for collecting revenue from health insurers.

PRINCIPAL FINDINGS

The State Department of Mental Health Does Not Ensure That Counties Bill Insurers as Required by State Law

In our March 1985 report, we recommended that the department ensure that counties obtain necessary billing information from clients at the time and place that the clients receive mental health services, bill insurers, and follow up on unpaid claims. However, the department has not implemented these recommendations, and the counties continue not to bill health insurers for the full cost of treatment. Alameda, Los Angeles, and San Francisco counties neither obtain all the information needed to bill insurers nor follow established billing procedures. For example,

in Alameda County, staff did not obtain a client's signature authorizing the insurer to pay the county for treatments, and consequently, the county was unable to bill the insurer for $6,242. In addition, the counties do not follow established procedures for billing health maintenance organizations. As a result of these continuing problems, we estimate that the State's mental health system lost approximately $653,000 in insurance revenue for mental health treatments given to clients in Alameda, Los Angeles, and San Francisco counties during fiscal year 1985-86.

The State Department of Mental Health Does Not Maintain Accurate Data on Sources of Payment for Its Clients

For two of the three counties that we reviewed, the department's information system, known as the "Client Data System" (CDS), contained inaccurate information about whether clients entering the mental health system have health insurance. For example, the CDS reports that only 3.7 percent of the individuals who entered the mental health program in Los Angeles County in fiscal year 1985-86 had health insurance although we estimate that 12.4 percent had insurance. As a result of this inaccurate data, the Legislature, the governor, the department, and other users of the CDS do not have the information that they need to effectively manage the State's mental health funds and, consequently, could make decisions based on incorrect information.

The department's data is inaccurate because the department does not provide clear guidance to counties on reporting potential sources of payment for treatment and does not ensure that the information it receives accurately reflects the information in the counties' files.

RECOMMENDATIONS

To ensure that counties bill insurers for the costs of treatment for privately insured clients and to ensure that it maintains accurate information, the State Department of Mental Health should take the following actions:

- Implement our March 1985 recommendation to monitor the counties' billing practices;
- Monitor counties to ensure compliance with established billing procedures for members of health maintenance organizations;
- Impose administrative sanctions to enforce state requirements if counties do not comply with required billing procedures; and
- Ensure that information in its Client Data System is correct.

AGENCY COMMENTS

While the Department of Mental Health does not disagree with our findings and recommendations, it believes that we have not fully recognized the progress that it has made in collecting revenue from sources other than private insurance. In addition, the department believes that the Client Data System is still too new to play a major role in program management.

INTRODUCTION

The State Department of Mental Health (department) and each of the 58 counties in the State share responsibility for administering the public mental health system in California. The department coordinates statewide efforts to treat and prevent mental disabilities, oversees the programs that the counties develop, distributes state funds to counties, and provides direct services to mental health clients in state hospitals. The counties provide or contract to provide services directly to mental health clients.

Mental health services include prevention and control of mental illness through outpatient care, 24-hour treatment and care, and day care. Outpatient care includes an evaluation of the nature or cause of the client's condition, individual and group therapy, medication services, and emergency treatment. Outpatient services are provided at clinics, hospitals, and other facilities. Twenty-four hour services provide care and treatment within a residential setting. Depending on the severity of a client's mental disorder and his or her need for treatment, care is provided by state hospitals, local hospitals, psychiatric health facilities, skilled nursing facilities, licensed residential care facilities, and jail inpatient units. Day care, including vocational and other services, provides alternatives to inpatient care. Day care is provided at community care facilities, skilled nursing facilities, and other settings.

In fiscal year 1985-86, the department spent $770.3 million, of which $751.2 million was provided by the State's General Fund. For fiscal year 1987-88, the department's budget is $933.7 million; the State's General Fund is expected to provide $884.3 million (95 percent) of this amount. During fiscal year 1985-86, it cost Alameda, Los Angeles, and San Francisco counties approximately $206.7 million (45.8 percent) of the $451.3 million that it cost to provide mental health treatment statewide. Approximately 250 different organizations, both county operated and those with which the counties contracted, provided mental health treatments in Alameda, Los Angeles, and San Francisco counties during fiscal year 1985-86.

The money used to pay for the State's mental health system comes from a number of sources: the State's General Fund, county funds, federal funds from the Medi-Cal and Medicare programs, the clients, and the clients' health insurance. The counties must determine each client's ability to pay for treatment by completing a financial questionnaire that identifies the client's income, expenses, insurance coverage, and eligibility for Medicare and Medi-Cal. The counties are required to bill insurers for the full cost of mental health treatment. The counties rely on the information that the clients give them about the clients' health insurers and do not normally obtain copies of the clients' insurance policies.

As the agency responsible for coordinating the State's mental health program, the department administers the Short-Doyle Act. The Short-Doyle Act established a system to provide a continuum of support services at the community level for mental health clients. The department, in consultation with the California Conference of Local Mental Health Directors and the California Council on Mental Health, establishes a broad policy for the delivery of mental health services statewide and establishes priorities, standards, and procedures according to which the mental health programs operate.

The Short-Doyle Act requires counties to submit annual plans to the department or negotiate contracts with the department that specify how the counties will provide mental health services in their communities. These plans and contracts are the basis for reimbursement from the State's General Fund for 90 percent of the net costs of local mental health services; the counties provide the remaining 10 percent.[1] For inpatient services provided at state and local hospitals, the State's General Fund reimburses 85 percent of the net cost, and the counties provide the remaining 15 percent.

Not all health insurers are required by law to provide mental health coverage. However, in fiscal year 1985-86, insurers paid

---

[1]The State waives the requirement for counties to provide the remaining 10 percent for those counties with a population of less than 100,000. However, the Legislature expects these counties to provide as much as possible of the 10 percent in funding.

approximately $10 million for treatments provided by the Short-Doyle mental health system. We define health insurers to include organizations that pay for all or portions of the cost of health care and organizations that provide or arrange for the provision of health care to their members.

Scope and Methodology

The Office of the Auditor General conducted this audit to determine how many people entering the public mental health system have private insurance coverage, the types of mental health coverage they have, and whether the counties were complying with state requirements for billing health insurers for mental health treatments. Table A-1 in Appendix A lists the health insurers that paid for portions of treatments given to insured clients in our samples and the types of treatments for which health insurers paid. Although health insurers are not all required by law to provide mental health coverage, we were also asked to estimate how much the public mental health system would save if all private health insurers covered mental health treatment. This estimate is provided in Appendix B, which also presents the cost of mental health treatments for privately insured clients in the three counties.

To determine how many people entering the public mental health system have private health insurance, we obtained from the department's information system, known as the "Client Data System" (CDS), three

listings of a total of 86,000 clients entering the mental health programs in Alameda, Los Angeles, and San Francisco counties during fiscal year 1985-86. We reviewed the accuracy of the data in these listings; we did not test the overall reliability of the CDS. The listings of clients included a financial responsibility code that indicates whether the clients had health insurance. To determine whether the information in the CDS accurately reflected whether or not those clients had health insurance, we reviewed county financial and treatment files for three random samples totaling 215 clients from the three CDS listings. From the results of this review, we estimated the number of people entering the mental health system with health insurance.

In Alameda County, we reviewed 84 client files and estimated, based on a 90 percent confidence level, that at least 4.3 percent but not more than 14.8 percent of the clients entering the mental health system in fiscal year 1985-86 had private health insurance. In Los Angeles County, we reviewed 81 client files and estimated, based on a 90 percent confidence level, that at least 6.3 percent but not more than 18.4 percent of the clients entering the mental health system in fiscal year 1985-86 had private health insurance. We estimated the number of clients entering the mental health systems with health insurance in Alameda and Los Angeles counties because the error rate in the CDS data for those counties exceeded our expected error rate of 10 percent. For both counties, we present the midpoint of our estimated range as the most useful information for the Legislature. In

San Francisco County, we reviewed 50 client files and found that the error rate in the CDS data for clients entering the mental health system with private health insurance was less than 10 percent at the 90 percent confidence level.

To determine the kinds of mental health treatments covered by health insurers and how much the public mental health system could save if all health insurers covered mental health treatment, we reviewed insurance billing and payment records in the three counties for all the treatments given to random samples of a total of 307 insured clients during a single episode of treatment in fiscal year 1985-86. (A treatment episode includes all the treatments provided to a client from the time a provider admits the client to a treatment plan until the provider discharges the client from that treatment plan.) We reviewed files for 94 clients in Alameda County, 113 clients in Los Angeles County, and 100 clients in San Francisco County.

In addition, we used the same insurance billing and payment records to determine whether the counties were complying with state requirements to bill health insurers for mental health treatments. However, because of errors in the CDS, members of health maintenance organizations (HMOs) were underrepresented in our billing review in Los Angeles County. Consequently, our estimate of foregone revenues for Los Angeles County is low. Insurance companies pay the providers of services for the cost of treating their insured clients while HMOs provide services directly to their enrollees or pay others to provide services.

In addition, from financial and treatment files for the 307 insured clients in Alameda, Los Angeles, and San Francisco counties, we collected information regarding the cost of treatments given to the clients during their single episodes of treatment, the amounts the counties billed to health insurers for the treatments, the amounts the counties received from insurers for the treatments, and whether the counties made efforts to collect unpaid claims from insurers. Using this information, we determined what percentage, on average, health insurers paid for mental health treatments given to clients whose files indicated that they had health insurance. For the three counties, we estimated the costs of treatment given to clients with health insurance and the amounts billed to health insurers for those treatments. Using these estimates and the average percentage of billed treatments paid by insurers, we estimated how much the mental health system lost as a result of the three counties not always billing health insurers for the full cost of single episodes of treatment. For Alameda County, we estimated that the mental health system lost at least $65,000 but not more than $392,000. For Los Angeles County, we estimated that the mental health system lost at least $62,000 but not more than $341,000. Finally, for San Francisco County, we estimated that the mental health system lost at least $135,000 but not more than $314,000. For all three counties, we present the midpoint of our estimated range, and we calculated all of these ranges at the 90 percent confidence level.

Furthermore, of our sample of 307 insured clients in the three counties, at least 123 had mental health coverage. We used the financial and treatment files for these 123 clients to determine the average percentage health insurers paid for the clients' mental health treatments. We estimated the costs of the treatments. We also estimated how much the mental health system could have saved in the three counties during fiscal year 1985-86 if all health insurers provided the same mental health coverage as those insurers that do provide mental health coverage and if the three counties billed health insurers for the full cost of treatments.

Our audit focused on county efforts to bill health insurers for the costs of mental health treatments. We did not review county billings to or revenues from other sources of revenue, such as the federal Medicare program, the State's Medi-Cal program, or clients who may be responsible for a portion of the cost of their treatment.

Finally, we presented the results of the audit to each of the county mental health departments that we reviewed. We took the concerns of the county mental health departments into consideration in the audit report.

AUDIT RESULTS

I

THE STATE DEPARTMENT OF MENTAL HEALTH DOES NOT ENSURE THAT COUNTIES BILL INSURERS AS REQUIRED BY STATE LAW

The State Department of Mental Health (department) does not enforce state requirements for collecting revenue from health insurers for mental health treatments. As a result, we estimate that, in fiscal year 1985-86, the State's mental health system lost approximately $653,000 in insurance revenue because staff of three county mental health programs did not always bill health insurers for the full cost of mental health treatments. In March 1985, we also noted this and other deficiencies and recommended that the department enforce state requirements.

The California Welfare and Institutions Code, Section 7277, requires the department to determine liability and collect charges for care provided to clients in community mental health clinics. Section 5718 permits the director of mental health to delegate to counties the responsibility for charging and collecting treatment costs. Section 5718 further requires that, upon delegation of the responsibility, the director must establish policies and procedures for collecting charges and that each county to which responsibility is delegated must comply with the policies and procedures. The director

has delegated to each county the responsibility for determining the liability of clients to pay for treatments and for collecting charges from all liable parties including health insurers. The director has also established policies and procedures for collecting revenues from health insurers.

In addition, the California Welfare and Institutions Code, Section 5655, provides that if the director of the department considers that any county is substantially failing to comply with any provision of law, any regulation related to mental health services, or with the approved county Short-Doyle plan, the director may impose administrative sanctions to compel the county to comply. The director must order a hearing and, upon finding that a county is not complying, may take any or all of the following actions: withhold part or all of the state mental health funds; require the county to enter into negotiations to ensure compliance with the laws and regulations; and take appropriate legal action to compel the county to comply.

In March 1985, the Office of the Auditor General issued a report that included an audit of the department's revenue collection during fiscal year 1982-83 in Alameda, Los Angeles, and Sacramento counties. According to the report, entitled "The State's Mental Health System Could Be Operated More Cost-effectively and Could Better Meet the Needs of Clients," Report P-441, the counties failed to comply with policies and procedures requiring them to obtain enough information to bill health insurers. The report also found that counties failed to

bill health insurers for the full cost of treatment and failed to follow up on unpaid claims. The report recommended that the department enforce the state requirements. In May 1985, the department stated that, by August 1985, it would complete a revised manual detailing the department's policies and procedures and would provide training to the counties to correct the billing deficiencies that we identified in the report. The department did not complete the manual by August 1985 and, in March 1986, told us that it had enforced state requirements for billing health insurers but would issue the policy and procedures manual by July 1986. As of December 8, 1987, the department has prepared a draft of its revised manual, but the draft of the manual does not address specific problems such as how to bill health maintenance organizations. Further, although the department has provided some training to the counties regarding how to bill clients and Medicare for mental health treatments, the training did not address how to bill private insurers.

Counties Do Not Always Bill Insurers for the Full Cost of Mental Health Treatments

Department policy requires that counties make a reasonable effort to collect money owed for mental health treatments. To implement this policy and to comply with the state laws requiring counties to charge liable parties for treatments, the department has developed procedures for collecting revenues. The department's Uniform

Billing Guidelines and Procedures requires that counties always bill health insurers for the full cost of treatments provided to insured clients.

In fiscal year 1985-86, Alameda, Los Angeles, and San Francisco counties failed to bill health insurers for any treatments given to 137 (45 percent) of the 307 insured clients whose files we reviewed. Furthermore, these counties failed to bill health insurers for some of the treatments given to another 59 (19 percent) of the 307 clients. Table 1 shows the number of clients for which each county billed or failed to bill health insurers.

TABLE 1

NUMBER OF INSURED CLIENTS FOR WHICH THREE COUNTIES BILLED OR FAILED TO BILL HEALTH INSURERS FISCAL YEAR 1985-86

	Number of Insured Clients				
County	In County (Estimated)	In Sample	Billed for Full Cost of Treatment	Billed for Part of Cost of Treatment	Not Billed for Any Treatment
Alameda	886	94	18	14	62
Los Angeles	8,170	113	61	32	20
San Francisco	1,145	100	32	13	55
Total	10,201	307	111	59	137

The costs of mental health treatments given to clients with health insurance are substantial. During fiscal year 1985-86, Alameda, Los Angeles, and San Francisco counties provided treatments to an estimated 10,201 insured clients during their single episodes of treatment that we estimate cost at least $7.13 million. However, contrary to the department's procedures, the counties did not bill health insurers for the entire amount. Instead, we estimate that these counties billed health insurers for only $4.79 million (67.2 percent) of these costs. Our estimates are conservative because the total cost of insured clients' treatment and the total amount billed to health insurers include only those treatments given to clients during a single episode of treatment during the year. Many clients in the mental health system receive more than one episode of treatment during a fiscal year. For example, clients we reviewed in San Francisco County began an average of 2.2 episodes during fiscal year 1985-86, and one of these clients began 21 episodes during the year. In addition, our estimates of the total cost of treatments and amounts billed in fiscal year 1985-86 do not include treatments that were a part of episodes that began in the prior fiscal year.

Although not all insurance billings result in payments from health insurers, not sending bills at all ensures that the counties will not receive insurance revenue. While health insurers paid Alameda, Los Angeles, and San Francisco counties an estimated $1.33 million (27.8 percent) of the $4.79 million that the counties billed to health insurers in fiscal year 1985-86, the department did

not ensure that counties billed health insurers for approximately $2.35 million in treatment costs. As a result of the counties not billing health insurers for this amount, we estimate that the State's mental health system lost approximately $653,000 (27.8 percent of the unbilled $2.35 million) in insurance revenue that it could have collected if the counties had billed insurers for the full cost of mental health treatments and if insurers had paid 27.8 percent of the total treatment costs. For each county, Table 2 shows our estimates of the cost of treatments given to insured clients, the amounts billed to and received from health insurers, the amounts not billed to health insurers, and the amount of insurance revenue lost by not billing health insurers.

TABLE 2

ESTIMATES OF THREE COUNTIES' COSTS FOR MENTAL HEALTH TREATMENT, THE AMOUNTS BILLED TO HEALTH INSURERS, AND THE AMOUNTS LOST FISCAL YEAR 1985-86 (IN THOUSANDS)

County	Total Cost	Billed to Insurers	Received From Insurers	Not Billed to Insurers	Estimated Lost Revenue
Alameda	$1,044	$ 225	$ 63	$ 819	$228
Los Angeles*	4,524	3,800	1,060	724	201
San Francisco	1,564	760	212	804	224
Total	$7,132	$4,785	$1,335	$2,347	$653

* We were unable to determine the full cost of treatments given to members of health maintenance organizations in Los Angeles County or the extent to which the county failed to bill health maintenance organizations for their members' treatments because of errors in the department's information system.

In addition to the $653,000 that we estimate Alameda, Los Angeles, and San Francisco counties could have collected from health insurers during fiscal year 1985-86, the State's mental health system lost more revenue that Los Angeles County could have collected from health maintenance organizations (HMOs). Providers of mental health treatments in Los Angeles County did not properly identify clients who were covered by HMO contracts as having insurance when submitting information to the department's information system, known as

the "Client Data System" (CDS). (See Chapter II for a more detailed discussion of errors in the CDS.) Because we used the CDS to select samples of clients, HMO members were underrepresented in our sample of clients in Los Angeles County. As a result, costs of treatments to some clients in Los Angeles County with HMO coverage are not included in the total cost of treatments that we estimate were provided to clients with health insurance. For example, by reviewing 38 files at three treatment providers in Los Angeles County, we determined that the three providers failed to bill one HMO for at least $21,904 in additional treatment costs in fiscal year 1985-86. The counties are required to bill HMOs, as they would other health insurers, for the full cost of mental health treatment.

While the department has established some policies and procedures for billing health insurers, has communicated these to the counties, and makes periodic visits to the counties to attempt to verify that they are complying with these policies and procedures, the department does not always identify deficiencies, and, therefore, cannot use administrative sanctions or other means to make counties comply. The department's Program Review Section is responsible for periodically reviewing the counties' compliance with the State's requirements for its mental health program and attempts to conduct these reviews at each county once every three years. During a review, a team of at least five reviewers measures a county's performance in organizing, administering, and operating the local mental health program. However, only a small portion of the program review manual covers revenue collection.

As part of the revenue collection review, the team must determine whether the county obtains necessary information from clients at the time and place that the clients receive mental health services, bills insurers for the full cost of treatment, and follows up on unpaid claims. However, we found that the program reviews do not always make these determinations. During the most recent review of Los Angeles County, conducted in fiscal year 1985-86, the review team did not note any significant failure related to these areas of revenue collection. However, we found that the county was deficient in all of the areas during that year.

Because the department has not enforced its procedures for billing and collecting insurance revenues, Alameda, Los Angeles, and San Francisco counties have not complied with those procedures. The department's procedures require counties to obtain all client information necessary to bill health insurers. However, in 37 of the 137 cases in which counties failed to bill health insurers, the counties did not obtain necessary financial information from clients at the time and place that the clients received mental health services. For example, in 23 of the 37 cases, the counties failed to obtain client signatures authorizing insurers to pay the counties. In Alameda County, usually no one attempted to obtain these authorizations until the county's billers began to prepare claims to the insurers. One client was admitted to a hospital in that county on January 28, 1986. On January 29, county staff determined that the insurer would pay 100 percent of the cost of mental health treatments that would be given

to the client during the first 21 days. The hospital discharged the client on February 12, 15 days after the client was admitted. The cost of the client's treatments totaled $6,242. However, the county did not attempt to obtain the client's signature authorizing the insurer to pay the county until March 5, 1986. The county was unable to obtain the client's signature, did not bill the insurer, and did not receive any payments from the health insurer.

Further, although the department requires counties to bill HMOs for the full cost of mental health treatments given to HMO members, the counties have not complied. Staff responsible for billing insurers told us that they believe that certain HMOs will refuse to pay claims because, when they did bill the HMOs in the past, the HMOs rejected the claims. However, we found little evidence in the files to support the conclusion that the HMOs would not pay any claims. In fact, we found evidence that, in some cases, the HMOs paid claims and in other cases they would have paid claims if the counties had submitted them to the HMOs. For example, in San Francisco County, one treatment provider obtained HMO approval for $4,403 in treatments for two clients in our sample, but, because the county programmed its billing system so that it would not generate claims to HMOs, the county did not bill the HMO for these treatments. As a result of believing HMOs would refuse to pay claims, the three counties did not bill health insurers in at least 53 of the 307 cases that we reviewed. The total cost of treatments provided to clients in these cases amounted to $93,683.

Finally, the department's lack of enforcement has contributed to other conditions that we found. For example, in October 1984, the department instructed counties to notify one HMO within 48 hours of having begun emergency treatment to its members. The department also instructed counties to recommend that the HMO's members obtain nonemergency treatment from the HMO. These instructions are consistent with the HMO's requirements. However, of 48 cases in which the counties provided emergency treatments to HMO members, we found documentation for only two cases in which treatment providers notified the HMO of emergency treatments. In addition, we found documentation that indicated that the HMO was aware of only six other cases in which its members were receiving emergency treatment from the counties. Further, we found documentation of only one case in which treatment providers referred the HMO's members to the HMO for nonemergency treatment. Also, the HMO required treatment providers to obtain its authorization before treating its members for nonemergency treatment. In only 8 of 99 cases did treatment providers obtain HMO approval for nonemergency treatments to HMO members.

Counties Do Not Always Follow Up With Insurers for Unpaid Claims

According to the department's guidelines and procedures, counties should contact insurers by mail or telephone to determine the status of unpaid claims if the counties have not received a response from the insurers within 30 days after submitting a claim. In addition, counties should submit follow-up claims specifying that they

are following up on previously submitted claims. However, the three counties failed to submit follow-up claims totaling $6,760 to insurers in 21 (35 percent) of 60 cases in which the insurers did not respond to the first claim. In addition, in 4 of the 21 cases, insurers paid portions of claims in the past for the same types of treatments previously given to the same individuals, indicating that they may have paid portions of the latest claims if the counties had followed up with the insurers. As a result of the counties not always following up on unpaid claims, the State's mental health system could be foregoing additional insurance revenue.

The counties did not follow up on unpaid claims because they did not always identify overdue claims that required additional attention. In addition, when we asked the director of the department why the department has not enforced the State's requirements for billing health insurers, he stated that the department has assigned a higher priority to the more effective pursuit of other revenue sources, such as Medicare, for mental health treatments.

CONCLUSION

The State Department of Mental Health does not enforce state requirements for collecting revenue from health insurers for mental health treatments. As a result, we estimate that, in fiscal year 1985-86, the State's mental health system lost approximately $653,000 in insurance revenue because staff of

three county mental health programs did not always bill insurers for the full cost of mental health treatments. The department has not enforced the State's requirements for billing health insurers because it has assigned a higher priority to the more effective pursuit of other revenue sources.

RECOMMENDATIONS

To ensure that the counties bill insurers for the costs of treating privately insured clients, the State Department of Mental Health should implement the recommendations that we made in our March 1985 report. In the report, we recommended that the department ensure that counties take the following actions:

- Obtain necessary billing information from clients at the time and place that the clients receive mental health services;

- Bill insurers for the full cost of mental health treatments given to insured clients; and

- Determine when insurance claims are past due and follow up with health insurers.

In addition, to ensure that the counties follow the specific requirements of the health maintenance organizations that the counties deal with, the department's Program Review Section, in the course of its periodic reviews, should monitor the counties to ensure that they take the following actions:

- Notify all HMOs within the time limits specified by the HMOs when they are beginning emergency treatment for HMO members; and

- Refer HMO members to the HMOs for nonemergency treatments or obtain written agreements from the HMOs to pay counties for providing nonemergency treatments to their members.

Further, the counties should comply with state requirements for billing insurers for the full cost of treatments provided to insured clients and for following up on unpaid claims. If a county fails to comply with required billing procedures, the director of the department should impose on the county the administrative sanctions cited in the Welfare and Institutions Code, Section 5655, to help ensure that the county meets state requirements.

II

THE STATE DEPARTMENT OF MENTAL HEALTH DOES NOT MAINTAIN ACCURATE DATA ON SOURCES OF PAYMENT FOR ITS CLIENTS

The State Department of Mental Health (department) does not maintain accurate data on the potential sources of payment for clients receiving treatment in the State's mental health system. As a result, the Legislature, the governor, the department, and other users do not have the information that they need to effectively manage the State's mental health system and could make decisions based on incorrect information. The department's data is inaccurate because the department has not provided clear guidance to counties on reporting potential sources of payment for treatment and has not ensured that the information that it receives from each county is accurate.

To assist the Legislature, the Department of Finance, the department, the Office of Statewide Planning and Development, and the county mental health programs to effectively manage mental health funds, the Welfare and Institutions Code, Section 5656, requires the department to collect data on each client receiving treatment in the State's mental health system. One of the elements of information required by the law is a financial responsibility code. Financial responsibility codes, as defined by the department, identify all expected sources of payment for a client's treatment, including private insurance.

In the past, the Legislature, the Department of Finance, the department, and the counties have had to rely on information collected through informal surveys to make decisions affecting the State's mental health system. According to the department's chief of statistics and data analysis, this information, in some cases, included a number of counties' best guesses as to the number and types of clients served in those counties. In addition, because consistent statewide data had not been collected, the department had difficulty in making comparisons among counties with regard to types of clients served and treatments needed. Recognizing that administrators and managers require accurate information to make effective decisions, and in response to the state law, the department created an information system known as the "Client Data System" (CDS). Fiscal year 1985-86 is the first year for which the department collected data from all the counties.

Because the need for accuracy must be weighed against the cost of attaining accuracy, generally accepted data processing procedures require organizations such as the department to define the level of accuracy expected of the information system and establish a system of controls to ensure that the system meets that level. Systems of controls include periodic on-site reviews to determine if information in the data base accurately reflects the information in the source documents. For example, the California Department of Justice, which maintains a similar information system, has established data quality control procedures that include conducting on-site reviews to verify the accuracy of the information in the system.

The department does not know the extent to which information in the CDS is accurate and has not defined the required level of accuracy for the CDS. During our review of three counties, we tested the accuracy of information in the CDS related to whether individuals entering the public mental health system in fiscal year 1985-86 had private health insurance. For two of the three counties that we reviewed, the CDS contained inaccurate information. For example, the CDS reports that 3.7 percent of the 66,154 individuals who entered Los Angeles County's mental health program in fiscal year 1985-86 had private health insurance. However, by reviewing a sample of county files and testing data in the CDS, we estimate that 12.4 percent had private health insurance. Also, the CDS reports that 18.6 percent of the 9,305 individuals who entered Alameda County's mental health program in fiscal year 1985-86 had private health insurance. However, by performing similar reviews and tests in Alameda County, we estimate that only 9.5 percent had private health insurance. In contrast, the CDS accurately reported that 11 percent of the 10,412 individuals who entered San Francisco County's mental health program had private health insurance.

As a result of inaccuracies in the CDS, the Legislature, the governor, the department, and other users do not have accurate information by which to manage mental health funds and could make decisions based on inaccurate information. For example, the Legislature asked the Office of the Auditor General to provide information regarding the number of insured clients so that it could

make more effective decisions related to the mental health program. To respond to the Legislature's questions about the mental health system and to determine whether the counties bill health insurers for treatment costs, we randomly selected from the CDS three samples of clients in three counties who, according to the CDS, had health insurance. However, because the CDS erroneously reported that many members of health maintenance organizations (HMOs) in Los Angeles County had no health insurance, our sample did not include many of the individuals whose files indicated that they were members of HMOs. As a result, we were unable to estimate the full extent to which Los Angeles County failed to bill health insurers and the full extent to which the public mental health system has foregone insurance revenue.

Also, according to the chief of the department's Information Systems Branch, one of the primary reasons for establishing the CDS was to allow the department to make comparisons among the counties. However, we believe that if the department were to use information from the CDS in evaluating the performances of Los Angeles and Alameda counties in billing health insurers or make a decision allocating resources to these counties based on the CDS's percentages of clients having insurance, the resulting allocations would be inappropriate.

The CDS contains inaccurate information because the department did not provide counties with clear instructions for assigning financial responsibility codes and, in some cases, did not provide codes to describe potential sources of payment. For example, Alameda

County assigns the department's code for insurance to clients who have no health insurance but whose treatments may be covered by other sources of money for which no code exists. If the department had provided a code for cases that were not covered by other codes or given clear instructions to the counties on how it defined health insurance coverage, these errors may not have occurred. In addition, some treatment providers in Los Angeles County assign codes to HMO members that indicate that the members have no health insurance because staff responsible for billing insurers believe that HMOs will not pay for their members' treatments and because the department has not ensured that treatment providers always assign insurance codes to HMO members.

Further, the department does not conduct the on-site reviews necessary to ensure that the information it receives accurately reflects the information in the counties' files. If the department had conducted on-site reviews for accuracy at Alameda and Los Angeles counties, it could have detected the counties' problems and could have taken action to correct them.

Finally, the department's director stated that the department had not yet established the required levels of accuracy because the CDS contains only two years of data. However, he said that the data subcommittee of the California Conference of Local Mental Health Directors will address required levels of accuracy for the CDS at its meeting in December 1987. The department's director also stated that the department has always intended to verify the accuracy of the data

in the CDS but that the department has assigned a higher priority to the system's design and development and collecting data from all the counties. He said that the department should be able to redirect its efforts to ensure the accuracy of the data beginning with the next fiscal year at the latest. The director stated that the department plans to verify the accuracy of the data by periodically visiting the counties and reviewing procedures and county files.

CONCLUSION

The State Department of Mental Health does not maintain accurate data on the potential sources of payment for clients receiving treatment in the mental health system. As a result, the Legislature, the governor, the department, and other users do not have the information that they need to effectively manage the State's mental health system and could make decisions based on incorrect information. The department's data is inaccurate because the department has not provided clear guidance to counties on reporting potential sources of payment for treatment and has not ensured that the information that it receives from the counties is accurate.

RECOMMENDATIONS

To ensure that it maintains accurate information, the State Department of Mental Health should take the following actions:

- Explain to the counties how the department defines insurance coverage and provide clear direction on how counties should assign financial responsibility codes for the Client Data System;

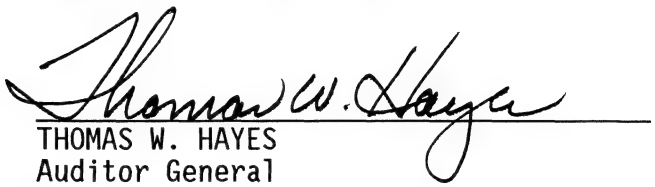
- Establish a required level of accuracy for the CDS;

- Implement its plans to review documents for a sample of clients during periodic visits to the counties to verify that the information in the CDS accurately reflects the information in the counties' files to the extent required by the department's standards for accuracy; and

- If the department finds inaccurate data in the CDS, it should take action to correct the errors.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: February 1, 1988

Staff: Sam Cochran, Audit Manager
William S. Aldrich, Audit Manager
Anthony F. Majewski
Ann K. Campbell
Graeme W. Johnson
Nancy L. McBride
Linda Solite

APPENDIX A

TYPES AND TERMS OF PRIVATE INSURANCE COVERAGE FOR CLIENTS IN THREE COUNTIES

This appendix describes the types and terms of private insurance coverage for samples of clients in Alameda, Los Angeles, and San Francisco counties.

Types of Insurance Coverage

During our review of the mental health programs in Alameda, Los Angeles, and San Francisco counties, we examined the files of 307 clients who received mental health treatments during fiscal year 1985-86. We were able to verify the insurance coverage of only those clients whose health insurers paid all or part of the claims sent to them. We could not identify the types of coverage of clients for whom the county did not bill health insurers, and we could not determine whether health insurers would have covered types of treatments other than those the clients actually received.

We identified 51 health insurers that paid all or part of the cost of treating 106 of the 307 clients whose files we examined. These health insurers paid for three types of services provided to clients. The most frequent type of coverage was for outpatient treatment, which was paid for by all 51 insurers. The other two types of treatment are 24-hour care and day care, which were paid for by 2 of the 51 insurers. Table A-1 lists the health insurers that paid claims and the types of treatments for which they paid.

TABLE A-1

A LIST OF HEALTH INSURERS THAT PAID CLAIMS FOR CLIENTS IN OUR SAMPLE AND THE TYPES OF TREATMENT FOR WHICH THEY PAID

Health Insurer	Type of Treatment: Out-Patient*	24-Hour Care	Day Care
Aetna Life & Casualty	X		
Allstate Life Insurance Company	X		
AMI Health Insurance Administrators	X		
Bay Pacific Health Plan	X		
Best Life Assurance Company of California	X		
Blue Cross of California	X	X	
Blue Cross Prudent Buyer Plan	X	X	
Blue Cross and Blue Shield of North Carolina	X		
Blue Shield of California	X		
Blue Shield Preferred Plan of California	X		
California Psychological Health Plan	X		
C.M.T.A.-I.A.M. Joint Health & Welfare and Dental Trust	X		
Cement Masons Health and Welfare Trust Fund for Northern California	X		
CHAMPUS/CHAMPVA	X		
Commercial Bankers Life Insurance Company	X		
Control Data	X		
Emerson Electric Benefit Trust	X		
Evans Products Employee Benefits Trust	X		
Great-West Life Assurance Company	X		
HEALS	X		
Health Maintenance Network of Southern California	X		
Health Service System City and County of San Francisco	X		
HealthAmerica-Rockridge	X		
Insurance Management Administrators, Inc.	X		
John Hancock Mutual Life Insurance Company	X		
Kaiser Foundation Health Plan, Inc.	X		
Laborers Health and Welfare Fund for Southern California	X		

* Outpatient treatments include an evaluation of the nature or cause of the client's condition, individual and group therapy, medication services, and emergency treatment.

Health Insurer	Type of Treatment		
	Out-Patient*	24-Hour Care	Day Care
Los Angeles Hotel-Restaurant Employer-Union Welfare Fund	X		X
Massachusetts Mutual Life Insurance Company	X		
Metropolitan Life Insurance Company	X		
N.A.L.C. Health Benefit Plan	X		
RCA Plan for Health	X		
Oakland Unified School District	X		
Operating Engineers Local 501 Security Fund	X		
Pennsylvania Life	X		X
Postmasters Benefit Plan	X		
Printing Industries Association, Inc. of Southern California	X		
Railroad Retirement Board	X		
Reliance Standard Life Insurance Company	X		
Sheet Metal Workers Health Plan of Southern California, Arizona and Nevada	X		
Southern California Edison Company	X		
Take Care Corporation	X		
The Equitable Life Assurance Society of the United States	X		
The Guardian Life Insurance Company of America	X		
The Lincoln National Life Insurance Company	X		
The Prudential Insurance Company of America	X		
The Travelers	X		
The Union Central Life Insurance Company	X		
Transamerica Occidental Life Insurance Company	X		
Unionmutual	X		
United Health Plan	X		

* Outpatient treatments include an evaluation of the nature or cause of the client's condition, individual and group therapy, medication services, and emergency treatment.

Terms of Private Insurance Coverage

Health insurers paying claims for clients in the counties that we reviewed provided a range of coverage for mental health treatments. Because the records of the clients in our samples did not contain copies of insurance policies, we interviewed staff of some health insurers that paid claims on behalf of clients in our sample to determine the terms of coverage provided for mental health treatments. Insurers providing coverage for clients in our samples paid from one percent of the cost of treatments to all of the cost. Some insurers did not provide coverage for some types of treatments. Also, in some cases, insurers required their clients to make co-payments for service or to pay a deductible for some part of the treatment cost. In addition, some insurers limited the number of treatments for which they would pay; others limited the amount that they would pay for treatments in a specified period. Finally, while insurance companies pay the providers of services for the cost of treating their insured clients, health maintenance organizations provide services directly to their enrollees or pay others to provide services.

APPENDIX B

THE COST OF MENTAL HEALTH TREATMENT FOR PRIVATELY INSURED INDIVIDUALS IN THREE COUNTIES

Alameda, Los Angeles, and San Francisco counties spent an estimated $15.7 million providing mental health treatments to insured clients during fiscal year 1985-86. According to the State Department of Mental Health's (department) revenue summary for fiscal year 1985-86, the three counties collected $1.9 million from health insurers for these treatments. Insurers paid such a small portion of the cost of mental health treatments for at least three reasons. First, health insurers are not all required by law to provide mental health coverage. Second, those insurers that do cover mental health treatments have limits on the number and types of treatments that they will cover and limits on how much of the cost that they will cover. Finally, as we have discussed in our report, the department does not ensure that the counties bill insurers for the full cost of treatment. Although not all health insurers are required by law to cover mental health treatments, if all health insurers had provided mental health coverage in fiscal year 1985-86, we estimate that the three counties could have collected $6 million from insurers for mental health treatments. Table B-1 shows the amounts that the three counties collected from health insurers for treatments during fiscal year 1985-86 and estimates of the amounts that the counties could have collected if all health insurers provided mental health coverage.

TABLE B-1

THREE COUNTIES' MENTAL HEALTH TREATMENT COSTS, REVENUE COLLECTED FROM HEALTH INSURERS, AND INSURANCE REVENUE IF ALL HEALTH INSURERS PROVIDED MENTAL HEALTH COVERAGE FISCAL YEAR 1985-86

County	Estimated Total Treatment Cost	Insurance Revenue Collected*	Insurance Revenue That We Estimate Could Have Been Collected
Alameda	$ 2,297,000	$ 309,000	$ 885,000
Los Angeles	9,953,000	1,229,000	3,837,000
San Francisco	3,441,000	355,000	1,326,000
Total	$15,691,000	$1,893,000	$6,048,000

* We obtained information for this column from the State Department of Mental Health's revenue summary for fiscal year 1985-86. We did not audit these figures.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF MENTAL HEALTH
1600 – 9th STREET
SACRAMENTO, CA 95814
(916) 323-8173

January 22, 1988

Thomas W. Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Mr. Clifford L. Allenby, Secretary of the Health and Welfare Agency, has asked me to respond to your report, P-715, entitled "The State Department of Mental Health Does Not Ensure That Counties Collect Revenue From Insurers and Does Not Maintain Accurate Data On Sources of Payment for Clients." Thank you for sharing your findings concerning your review. While we do not disagree with your findings or recommendations per se, we do not believe that the report fully recognizes the progress that has been made in revenue development and the relationships that exist between the counties and the Department of Mental Health (DMH) as envisioned by the current statutes. In addition, we are concerned that the report does not adequately recognize that the financial responsibility data which was reviewed represents only one of 36 data elements in the Client Data System (CDS) and that the system is still too new to play a major role in program management. Our response to each of your recommendations follows:

Chapter I. - Recommendation:

To ensure that the counties bill insurers for the costs of treating privately insured clients, the State Department of Mental Health should implement the recommendations that we made in our March 1985 report. In the report, we recommended that the department should ensure that counties take the following actions.

- Obtain necessary billing information from clients at the time and place that the clients receive mental health services;

- Bill insurers for the full cost of mental health treatments given to insured clients; and

- Determine when insurance claims are past due and follow up with health insurers.

In addition, to ensure that the counties follow specific requirements of the health maintenance organizations that the counties deal with, the department's Program Review Section should monitor the counties to ensure that they take the following actions:

- Notify all HMOs within the time limits specified by the HMOs that they are beginning emergency treatment for the HMO members; and

- Refer the HMOs' members to the HMOs for nonemergency treatments or obtain HMOs' written agreement to pay counties for providing nonemergency treatments to their members.

Further, the counties should comply with state requirements for billing insurers for the full cost of treatments provided to insured clients and for following up on unpaid claims.

Finally, if a county fails to comply with required billing procedures, the director of the department should impose on the county the administrative sanctions cited in the Welfare and Institutions Code, Section 5655, to help ensure that the county meets state requirements.

Response:

DMH will continue to require county mental health service providers to obtain, upon the initial visit or as soon as possible subject to individual circumstances, the billing information from clients. If clients have insurance, counties are instructed in the Uniform Billing Guidelines and Procedures to bill health insurers for the full cost of treatment. Furthermore, counties were instructed as part of the 15 Revenue Development Training Seminars held throughout the state from October 1985 through January 1986 that county programs should ensure that their financial intake staff are thoroughly trained in third party identification/claiming requirements and to establish a follow-up mechanism to obtain information necessary to complete third party claims. Forty-two counties were represented at the training by approximately 597 community program staff comprised of 183 clinicians, 129 administrators, and 285 support staff. (1) *The Department intends to reinforce its prior position by issuing a DMH letter to all counties reiterating the department's existing policy regarding financial intake procedures relating to insurance. Counties will also be instructed to bill at full cost for all services rendered and to follow up insurance claims with inquiries regarding past due claims and to resubmit claims as needed. This information is also contained in the DMH Revenue Development Policies and Procedure Manual, which is being readied for completion. It is scheduled to be printed and distributed to all counties and available to contract providers in the near future. It should be noted that while the manual will provide a useful aggregation of

---

* The Auditor General's comments on specific points contained in the department's response begin on page 43.

state and federal policies and guidelines pertaining to revenue development, virtually all of the contents of the manual have previously been distributed to counties through the all-county letter mechanism and are still in effect.

The Third Party Payors Identification and Claiming Section of the new manual incorporates policies relating to clients who are members of HMOs and PHPs. Counties are instructed to have procedures for clients who are members of PHPs and HMOs and to make timely contact with the applicable plans or organization to ascertain payment or provide the treatment. (2)

We agree in concept with the recommendation to use the DMH program reviews as a forum to monitor county compliance with HMO requirements and will explore expanding the scope of our review to delve into the area in more detail. The purpose of DMH's program reviews is to ensure that county programs have a system in place for mental health administration and the delivery of treatment services. The "Revenue Development" component applies to the entire revenue collection system following a standard protocol. All areas of revenue management and collection are reviewed, including patient fees, insurance, Medicare, Medi-Cal, federal grants, and other revenue sources. If a major deficiency is observed by the review team, it is brought to the attention of the county and a corrective plan of action is requested. While the Department has not used the specific administrative sanctions spelled out in W&I Code Section 5655, we believe the current corrective action plan process and subsequent enforcement of our concerns through review of county plans is consistent with the intent of this section.

The category of third party "insurance" revenues is an important item and it needs to be improved. However, since we believed there was a greater revenue potential in other areas, the DMH elected to place its primary emphasis (the last two years) on the more effective pursuit of Medicare and Medi-Cal revenue. DMH has conducted training, provided technical assistance and served as an advocate for counties in dealing with federal agencies and fiscal intermediaries. Subsequently, statewide Medicare revenue has increased by an estimated $10.3 million between FY 1983/84 and FY 1986/87. Medi-Cal Federal revenue increased over $30 million between FY 1983/84 and FY 1986/87 due primarily to program expansion and increased cost. However, a significant portion of the increase should be attributed to more efficient claiming procedures.

There is always room for improvement in all revenue collection activities. In this era of limited financial resources, it is important to maximize all revenue opportunities. For that reason, I am appreciative of your efforts and recommendations and will take action as appropriate.

Chapter II. - Recommendations:

To ensure that it maintains accurate information the State Department of Mental Health should take the following actions:

Recommendation #1.

Explain to the counties how the department defines insurance coverage and provide clear direction on how counties should assign financial responsibility codes for the Client Data System;

Response:

The Department concurs that it has a responsibility for achieving accurate reporting on all 36 Client Data System (CDS) data elements, including financial responsibility. The activities of training, instruction and correction have been ongoing since the initiation of CDS almost four years ago.

Information Systems Branch staff are in ongoing telephone contact with county staff regarding CDS reporting and definitions. Frequently, DMH staff make on-site visits to do face-to-face training. When problems of definition or application are found, we issue a CDS Information Notice to ensure understanding statewide.

As mentioned in the report, we have established a liaison relationship with the Data Subcommittee of the California Conference of Local Mental Health Directors (CCLMHD) and meet on a quarterly basis to resolve all data reporting issues, including those related to CDS. We also participate in the quarterly meetings of the several users' groups of county mental health automated systems in order to resolve data reporting and definitional issues.

Finally, the annual County Mental Health Data Processing Conference was originally initiated because of the introduction of the CDS; DMH actively participates in the planning and conduct of this conference. Two CDS workshops were part of the agenda of the November 1987 conference and were well attended by county personnel.

In summary, DMH attempts to use a variety of vehicles for instruction and for providing clear direction to improve the reliability of CDS reporting. It was gratifying to find San Francisco county, which has experienced growth in third party payments, to be accurate in reporting financial reporting to CDS. We will use San Francisco as a model in our discussions with other counties.

Recommendation #2.

Establish a required level of accuracy for the CDS.

Response:

We have begun a dialogue with the CCLMHD Data Subcommittee on the subject of acceptable levels of data reporting and tolerance of errors. We believe corrective action must be initiated at the data collection level in the county and will be accomplished more effectively through a collaborative effort rather than solely by DMH mandate.

The individual counties have an equal--if not greater--need for accurate data for purposes of effective management. Emphasis upon accuracy and quality control of data, therefore, must begin with the county level of data collection rather than with the secondary use of the data for reporting to CDS. Data quality assurance is not simple. CDS data is frequently being collected upon admission from a client who may be in a psychotic state and/or from a single visit contact. (3)

For this reason, we do not believe the comparison of CDS with the California Department of Justice (DOJ) information system is a valid one. CDS is intended to statistically describe and link the clients of the California mental health system and the services delivered. It is not intended as a system for tracking persons. In fact, Section 5656(c) of the Welfare & Institutions Code precludes the reporting of client names.

The DOJ system, on the other hand, is intended to track the criminal activities of identified felons. Given the consideration of public safety, the consequences of error demands a much higher level of accuracy and reliability. Also, the circumstances of data collection for these subjects, given the rigors of interrogation and detention, will accommodate a much lower tolerance of error than would be possible for CDS for the reasons discussed above. (4)

Recommendation #3.

Implement its plans to review documents for a sample of clients during periodic visits to the counties to verify that the information in the CDS accurately reflects the information in the counties' fields to the extent required by the departments' standards for accuracy;

Response (to Recommendation #3):

As quoted in the report, it is indeed our intention to conduct site visits, review data collection procedures and verify data accuracy by sampling county files. Such activities will be accomplished through redirection of staff efforts, as was the original development and implementation of the CDS at both the state and county levels. We anticipate that such redirections can be started in July 1988.

Recommendation #4.

If the department finds inaccurate data in the CDS, it should take action to correct the errors.

Response:

The CDS has a number of automated edit processes to reject incomplete, invalid and illogical data entries. During the past three years, the Department has committed, on the average, three full-time equivalent personnel to these error correction processes and related technical assistance to the counties. These efforts have been successful, as measured by the reductions in volume and frequencies of rejected data and turnaround documents. The reduction of errors will allow us to redirect staff effort to on-site monitoring as described earlier.

As a general response to the findings and recommendations in Chapter II, we are concerned that the report does not adequately recognize that financial responsibility is only one of 36 data elements in the CDS system and that the system is still too new to play a major role in program management. Certainly, as the system matures and as the data needs of users such as the Legislature, the Department and the counties become more defined, the accuracy of the data and its usefulness for management decisions will improve tremendously. (5)

Again, we thank you for the opportunity to review the draft report and provide you with our comments.

Sincerely,

For D. MICHAEL O'CONNOR, M.D.
Director

AUDITOR GENERAL'S COMMENTS ON THE DEPARTMENT OF MENTAL HEALTH'S RESPONSE

(1) The training seminars to which the department refers addressed the billing of Medicare and clients, not the billing of private insurers. As we state on page 11, the department has not provided training to the counties on how to bill private insurers.

(2) On January 25, 1988, after the completion of our audit fieldwork, the department provided us with a revised draft of its policy and procedures manual. The draft now includes policies related to health maintenance organizations.

(3) Because we recognized that mental health clients may not always provide accurate information to the counties, we did not evaluate the quality of the information obtained from the clients. Rather, we compared the information that the counties collected from the clients with the information in the CDS to ensure that they agreed.

(4) The department states that our comparison of the CDS with a system at the State Department of Justice (DOJ) is invalid because the systems have different purposes. In fact, the systems have similar purposes. Like the CDS, the DOJ's system was intended to provide broad statistics to the Legislature, the governor, and other entities. It was not intended as a device for tracking individual criminals. Furthermore, we do not claim that the department's CDS should attain the same level of accuracy as that of the DOJ's system. Instead, we state that the department needs to define a required level of accuracy for the CDS and ensure that the information in the CDS meets that level of accuracy.

(5) Our review focused on private health insurance. Therefore, we tested only the accuracy of the financial responsibility data. However, the director of the department confirmed that the department has neither established a required level of accuracy, nor conducted on-site visits to confirm the accuracy for any of the 36 data elements. Further, although the department states that the CDS is still too new to play a major role in program management, the system was mandated in September 1984. In October 1987, the deputy director of the Office of Information Technology concluded that the CDS should have been operational since at least October 1986.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps